They're getting you into the accreditation act

Joint Commission surveys lately are less like fault-finding inspections and more like seminars with members of the medical staff taking part. This text-and-picture tour in one hospital shows how the new-style accreditation visit works.

Text and photos by Allyn Z. Baum
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The Joint Commission on Accreditation of Hospitals is revamping its method of conducting accreditation surveys. Stung by past criticism, some of it justified, some not, the organization is unhappy with its image of badge-rattling inspector. The approach now being emphasized involves participation of hospital medical staffs.

Formerly, a Joint Commission surveyor would arrive at a hospital, huddle with the administrator, and chat with the chief of staff and director of medical records. Then he'd take perhaps a three-hour tour of the hospital's facilities and finally sit down—alone—to review the administrative and medical records. Shortly before leaving, he was likely to confer again with the administrator and chief of staff to impart his thoughts.

All this is changing. Now the surveyor or team of surveyors work not only with the administrator, chief of staff, and medical records director, but also with as many department heads and staff physicians as want to participate in a survey workshop. Together, they discuss such problems as privileges and the place of the G.P. in clinical services; they review the hospital's bylaws and the administrative and medical records.

This new approach makes a survey less an inspection and more of a frank, open, and sometimes heated series of panel discussions. And in the give and take over questions posed by the surveyors and the problems of the staff, the accreditation process becomes an educational experience. Half the time taken to conduct surveys is now devoted to such workshops. The so-called grand tour or "fingers along the molding" inspection of the hospital and its facilities is now being relegated to less of the surveyors' visiting time.

Prior to the accreditation visit, the hospital administration prepares its own survey report on a questionnaire forwarded by the Joint Commission. This report contains information about facilities and services; patient bed and service statistics; mortality data; the composition of the medical, dental, and nursing staffs; information about the physical plant, administration, medical staff or-

ganization; and descriptions of the various hospital departments. The report also advises what action the hospital has taken on recommendations made during the previous accreditation visit.

The surveyors usually make it a point not to review the hospital's last survey report until they complete their visit. Then, in company with the administrators and medical staff, they look at the hospital's own current report and the Joint Commission's last survey report and compare the findings.

That was the procedure followed when two surveyors visited the 400-bed Charles F. Kettering Memorial Hospital at Kettering, Ohio, recently. Named after inventor Charles F. Kettering, the ultramodern hospital received its first three-year accreditation in 1965, two

AROUND THIS TABLE *sit the hospital surveyors—and those being surveyed. The face-to-face confrontation illustrates the new look in Joint Commission procedures; surveyors used to work pretty much by themselves. Dr. Otto Arndal, one of two surveyors, holds up a history while leading a records workshop; doctors at Kettering (Ohio) Memorial Hospital participate in the review. Arndal found the records generally complete, except for some that had inadequate discharge summaries.*

years after its doors first opened. The 1968 surveyors were Dr. Otto Arndal, an assistant J.C.A.H. director in charge of the hospital accreditation program, and Dr. George T. R. Fahlund, a J.C.A.H. associate director who joined the commission last year. Arndal was an internist in private practice for 18 years before joining the commission four and a half years ago; Fahlund was a practicing surgeon for 30 years. The two men are implementing the new accreditation techniques devised under the direction of Dr. John Porterfield III.

At Kettering, the survey workshop took place in the hospital's spacious board room. Large as it is, however, it was jammed. Taking part, in addition to Drs. Arndal and Fahlund, were the hospital administrator and the assistant administrator, the president of the Kettering Medical Center of which Kettering Memorial is a part, the chief of staff, the director of nursing, and the medical records director. Also sitting in were various department heads and committee chairmen. Other members of the medical staff dropped in to watch, listen, and, at times, take part in the discussions.

As the group assembled, surveyor Arndal began the accreditation workshop by explaining: "We're not here to beat you over the head or look for shortcomings. We're not going to dictate to you how to run your hospital. Rather we want to work with you to help make the hospital a safe place for your patients and a safe place for you to practice. You'll find that our new approach to accreditation is through your [the medical staff's] participation in the survey. The more *you* bring to the discussions, the more you'll get out of the workshop."

Arndal added: "Of course, when we recommend something, the hospital can follow our proposal or not, as it sees fit. However, when we say 'should,' the hospital *must* do as we say; we're then making a requirement." Obviously, any hospital going against that might later risk loss of accreditation.

Looking into the hospital's newly revised but not yet adopted medical staff bylaws—the first order of business—both surveyors were complimentary but pointed to areas where they felt the bylaws could be improved. Together, they took exception to what they felt was an unreasonably high number on the courtesy staff. Of 467 physicians on the hospital staff, 290 were courtesy and only 136 active. Under the bylaws, it was noted, a courtesy staff member was defined as a member with privileges but no responsibilities except for medical records.

Turning to Dr. Richard Ireton, the chief of staff, Dr. Arndal observed: "All privileges and no responsibility can lead to serious difficulties. Your courtesy group is unrealistically large." (Later, the surveyors' report commented: "The medical staff and administration should carefully review the current roster of staff appointments to verify the frequency with which the physician admits and cares for patients, and participates in and contributes to staff organization and function, in order that the exercise of staff privilege may be commensurate with the exercise of responsibility.")

Analyzing utilization, Arndal

A PROFILE OF THE HOSPITAL *emerges from replies by Kettering's administrators to a questionnaire forwarded earlier by the Joint Commission. This self-survey of the hospital contains up-to-date information on its facilities, organization, and staff. The report also tells what the hospital has done to implement recommendations made during previous accreditation visits.*

FACILITIES AND SERVICES AVAILABLE—Check each of the following facilities and services available in your hospital:

- ☒ Blood Bank
- ☐ Cancer Clinic
- ☒ Central Sterile Supply Room
- ☒ Clinical Laboratory
- ☒ Dental Service
- ☒ Electrocardiograph
- ☒ Electroencephalograph
- ☒ Emergency Room
- ☒ Library, Medical
- ☒ Medical Records Department
- ☒ Occupational Therapy Department
- ☒ Outpatient Department
- ☒ Pharmacy ☐ Drug Room
- ☒ Physical Therapy Department
- ☒ Recovery Room (Surgical)
- ☒ Recovery Room (Obstetrical)
- ☒ Premature Nursery
- ☒ Radioactive Isotopes
- ☒ Rehabilitation Department
- ☐ Recreation Therapy Department
- ☐ Social Service Department
- ☒ X-ray, Diagnostic
- ☐ X-ray, Routine Chest on Admission
- ☒ X-ray, Therapeutic
- ☒ School of Nursing *
- ☒ Intern Program
- ☒ Resident Program
- ☒ Intensive Care Unit
- ☒ Personnel Health Program

* Located in the Kettering College of Medical Arts, the Educational Division of the Kettering Medical Center.

PATIENT BED AND SERVICE STATISTICS

Inpatient statistics (exclude newborns)

1. Bed complement (exclude bassinets) 400
2. Total inpatient admissions (exclude births) 15,424
3. Total inpatient days (exclude newborn infant days) 130,986
4. Average length of stay (exclude newborn infants) 8.5
5. Average daily census (exclude newborn infants) 358.9
6. Total obstetrical deliveries 1,679
7. Number of beds assigned to obstetrics 28
8. Number of beds assigned to pediatrics 36

Newborn infant statistics

9. Newborn infant bassinet complement 32
10. Total live births (exclude stillbirths) 1,675
11. Average daily census of newborn infants 24.6
12. Total newborn days 8,962

AUTOPSY—MORTALITY STATISTICS

Give the following statistics based on hospital deaths for the past year:	NUMBER OF DEATHS	NUMBER OF AUTOPSIES	PERCENT: AUTOPSIES / DEATHS X 100
Total (exclusive of Stillbirths)	374	142	38%
After 48 hours	289	117	40%
Post-operative within 10 days of operation	38	25	66%
Resulting from anesthesia	None	---	--
Maternal	None	---	--
Newborn	22	12	55%
Stillbirths	14	6	43%
Coroner's deaths autopsied in the hospital	8	---	--

MEDICAL STAFF

NUMBER OF MEMBERS

Honorary	3
Consulting	19
Active	136
Associate	8
Courtesy	290
Intern	10
Resident	1
Other	
TOTAL	467

DENTAL STAFF

NUMBER OF MEMBERS

	--
	--
	3
	1
	14
	18

and Fahlund wrote: "There has been considerable resistance on the part of the medical staff to allow the Record Committee to review and evaluate current charts for promptness. This situation is about to be overcome as the staff has accepted the philosophy of review by the Admissions Committee and the Length of Stay Committee, which are a part of required Utilization function.'

At Kettering, there is no utilization committee as such. Instead, responsibility for utilization is now divided among the admission, medical audit, and length-of-stay committees. Both the surveyors found this method of handling utilization highly commendable—each committee checking and being checked by the other. "Perhaps," put in Dr. Harold G. Kelso, secretary of the medical staff, "that's why we haven't any utilization problems."

The donnybrook of the survey developed over organization of the G.P.s and their place in the clinical services. Under existing bylaws and included in their proposed revisions, the G.P.s at Kettering are grouped in a clinical department without assigned beds. They meet monthly under their elected officers in their own department to review work done in the departments where they have privileges but no assignments.

"I regret that we must object to this," Arndal said. His objection was simply that, since the

SURVEY WORKSHOPS AND THE NOTES HE TOOK THERE *gave chief of staff Richard Ireton (below) and his colleagues a pretty good idea as to how the surveyors were sizing up the hospital. Thus the staff wasn't surprised at some of the observations and conclusions made by the surveyors and included in their accreditation report (opposite). It's on the basis of these conclusions that recommendations for changes in a hospital's administration and operation are made by the surveyors.*

6. The medical reference library contains:
   a. Current texts on the services rendered in the hospital. Yes_____ No_____
   b. Current periodicals on the services rendered in the hospital. Yes_____ No_____
   c. Basic science texts. Yes_____ No_____
7. There is documented evidence of satisfactory liaison with the governing board. Yes_____ No_____

N. P. C. The original bylaws of the medical staff were completed in 1965. These have just been rewritten and are in a preliminary draft form. This document has not been adopted by the staff, nor approved by the board. While this document in many respects improves on the original bylaws, a couple of points were discussed which need additional discussion and revision. First of these is the appeals clause, which fails to involve the board until a preliminary hearing of a staff committee has failed in reaching a satisfactory solution. The second major point relates to the organization of the general

(cont'd on p. #13)

Continuation Sheet

MEDICAL STAFF ORGANIZATION, cont'd -

practice session which, in the new bylaws, has become a clinical department without assigned beds. The general practitioners meet on a monthly basis for the review and evaluation of their work done in the different clinical departments where they have practice privileges, but no assignment. The inappropriateness of this approach was discussed at the summation conference in great detail, and after a lengthy discussion the reasonable conclusion would seem to be that the general practitioners are not welcome in the departmental meetings, which are attended solely by qualified specialists. It was further stated that to include the general practitioner as a member of a department where he exercises practice privileges would be an "insult" to the staff status.

The medical staff is departmentalized and meets together on a quarterly basis for purposes of organization and "business of the staff" as well as reports of Executive Committee. The clinical departments meet monthly. From the minutes recorded there appears to be an overemphasis on administrative discussions, and only a single paragraph devoted to the scientific portion of the meeting, and usually with no details of the cases presented and discussed.

The required administrative and clinical functions of the staff are carried out by committee structure, and all of the committees with exception of the Accreditation Committee record minutes, which adequately reflect the work accomplished. The Accreditation Committee is a small committee of the staff, and the need for a multi-disciplinary approach was discussed and recommendation made.

The unreasonable number (290) of courtesy staff members was discussed, and the subject of staff privilege and responsibility was covered in detail. The new bylaws define the courtesy staff member as a/member with privilege but without responsibility except for a medical record. The Chief of Staff admitted that this was a new philosophical approach and agreed to this more realistic approach.

department of general practice isn't a clinical service per se, clinical review and evaluation of patients should be done in the appropriate departments.

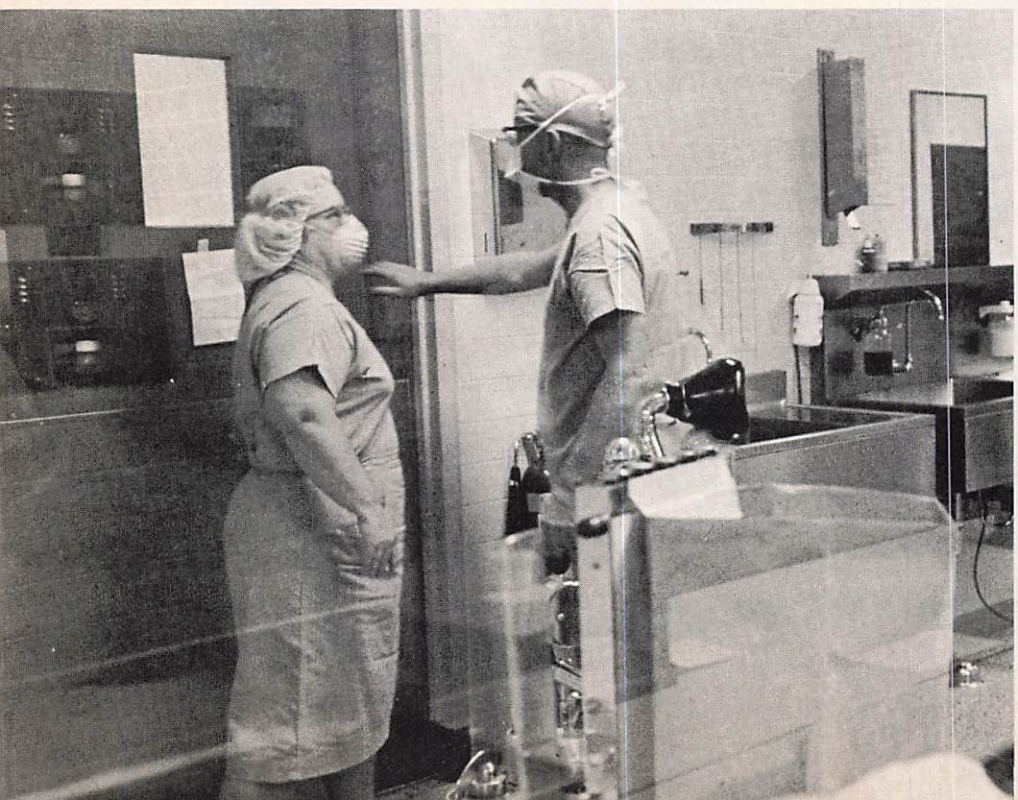
At that point Albert Hirsheimer, the chief of obstetrics, protested: "By saying that, you're causing bad blood between the G.P.s and the specialists." Other staff members murmured in agreement.

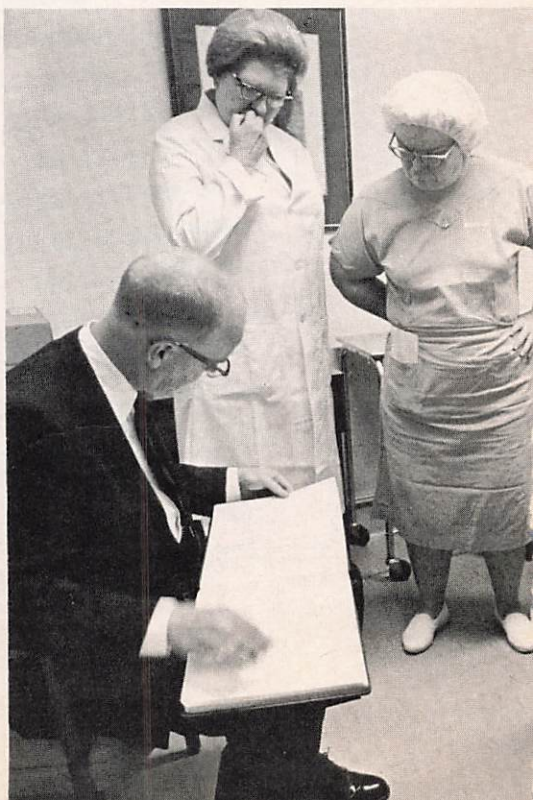
Arndal, however, refused to back away from his position. "You're trying to make the Joint Commission the goat in a situation in which your chief of staff and your other department chiefs recommend a clinical service without beds and then allow review of the G.P.s by themselves. This is irregular."

Chief of staff Ireton broke in and said: "I see nothing wrong with the situation, Dr. Arndal. I still maintain that the G.P.s should be involved." Then, at one end of the board room, a department head spoke above the hubbub and said: "I don't agree with you, Dick. Let's face it: To include a G.P. as a member of a department where he's exercising privileges would be an insult to staff status." (As a result of this episode, these comments later appeared in the commission's survey report: "It is recommended that the department of general practice be an administrative and educational department. Since [it] is not a clinical service and no patients are admitted . . . the members of the department should, on the recommendation of the credentials committee, have privileges on the clinical services of other departments in accord with their training and experience. The general practitioners should attend the departmental meetings in their ongoing clinical review and

"NO SCRUB GARB, NO TOUR." *That's how nurse Georgia Hart (left) greeted Dr. George Fahlund, the other J.C.A.H. surveyor, when he visited a Kettering O.R. Changed from street clothes, he praises Miss Hart for her strict adherence to rules, later reported: "Surgery is a tightly controlled department."*

STUDYING THE O.R. LEDGER *in the supervisor's office, Dr. Fahlund is impressed with its completeness. Reporting on the department of nursing, Fahlund noted, "The procedure manual is detailed and up to date,*





evaluation of patient care.")

With the bylaw discussion disposed of, the survey workshop turned to medical records and began to study a selection of 91 records that Arndal had asked for earlier in the morning. They represented a variety of cases from active files of the last year. Bizarre and unusual cases were excluded; the selected ones involved situations common to any hospital.

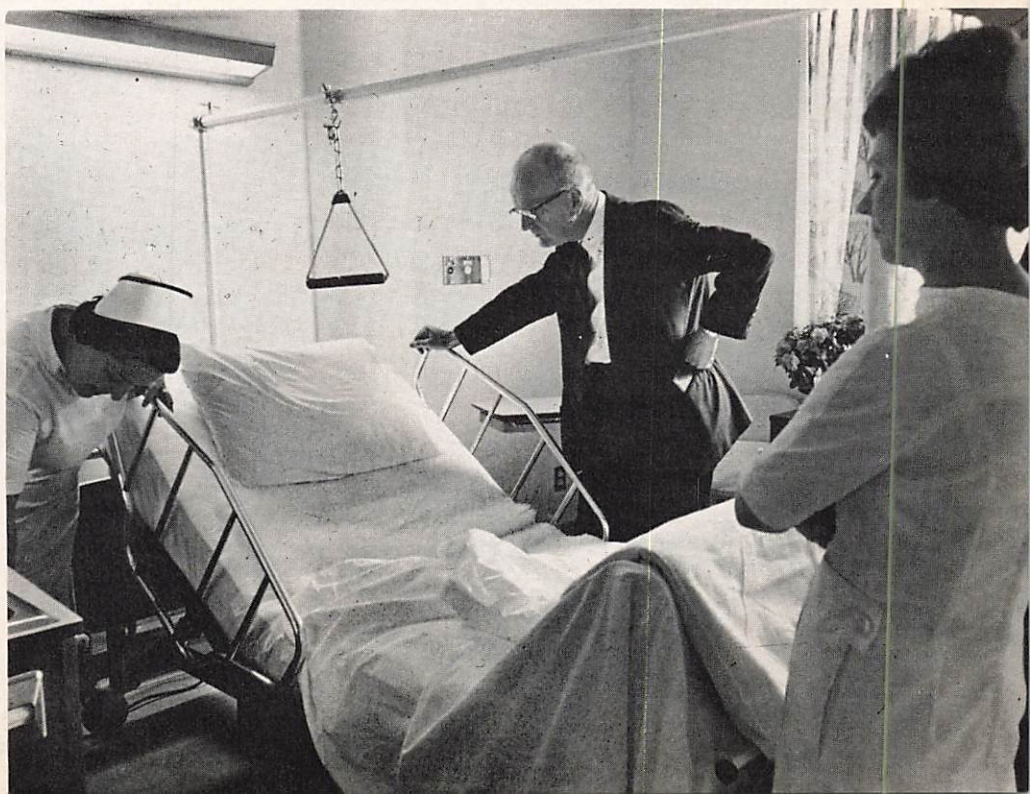
"This isn't going to be a clinical audit of medical records," Arndal said as he passed around a set of the records. "It'll be a workshop—a chance to look at yourselves as revealed in your medical records and see what you're doing right and what you're doing wrong."

The doctors seated around the table seemed startled. "Boy, is this a switch," Dr. Linus Rauch, chairman of the department of medicine, said to Dr. Ireton. "The last time a Joint Commission inspector was here, he ordered everyone out of the room and spent the next five hours going through the records by himself."

The surveyors then spent two hours reviewing the records, with the participation of staff members present. Later, reviewing the records of the various departments, the surveyors wrote in their report: "The records in the department of medicine were above average and in every instance included all pertinent physical findings, and the discharge summaries were excellent." Referring to the department of surgery, the report noted: "Operative reports on T. & A.s are recorded as a check-off and are a part of the short-form clinical record. In some instances, procedures were checked off and were not indicated in the discharge diag-

and the minutes of the nursing conferences are detailed and meaningful." He went on to describe the nursing stations as "well managed" and the nursing staff at Kettering "of very high caliber and morale."

PATIENT-OPERATED BED ADJUSTMENTS *intrigue surveyor Fahlund during his tour of the hospital. Besides being able to control the position of his bed, the patient has, within easy reach, a sink, telephone, room-light control, two-way nurse call, and remote control for radio tuning and TV viewing.*



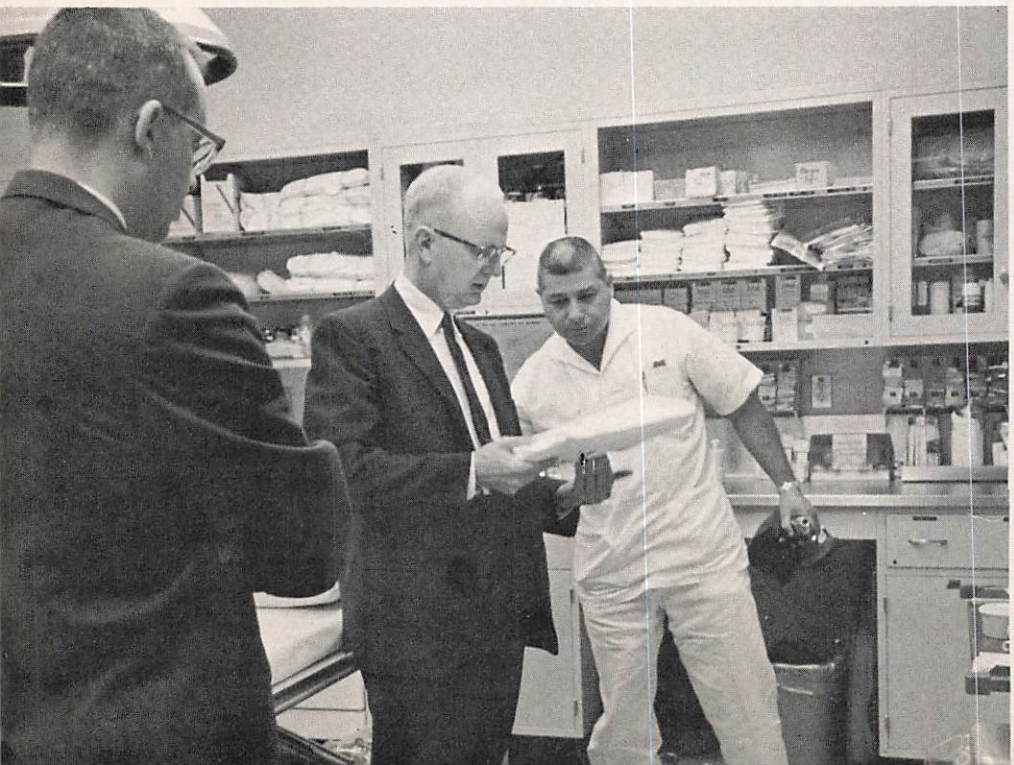
nosis on the front sheet." Turning to the OB department, the surveyors observed: "The prenatal record includes a detailed record of the first visit but, for the most part, subsequent prenatal visits are not included in the record. Patients delivered by caesarean section as well as post-partum tubal ligations have no preoperative physical examination recorded."

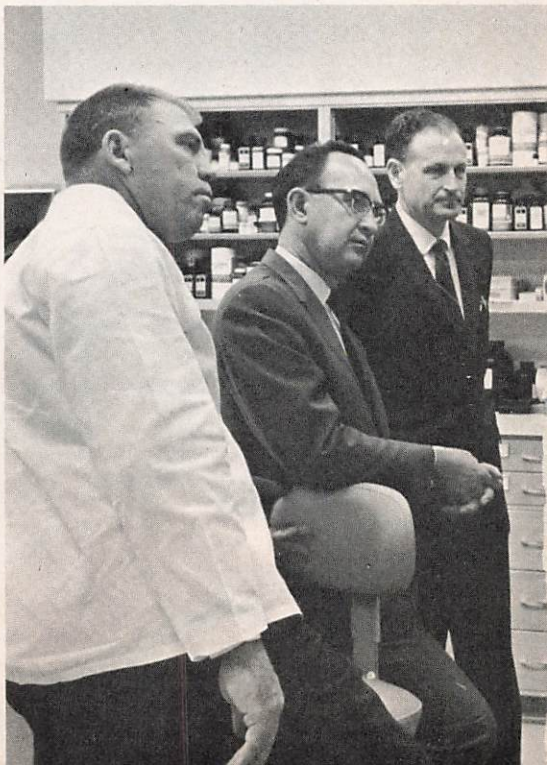
In their final comments and recommendations concerning records, Arndal and Fahlund made these suggestions: "The staff rules in regard to promptness and delinquency of medical records should be thoroughly enforced in order that current records may be completed within 24 hours of admission, and discharge records completed within 10 to 15 days. . . . All clinical records of patients hospitalized more than 24 hours, except normal obstetric and newborns, should have a complete discharge summary written and recorded, as suggested by the Joint Commission." The survey also found that there were no dietary notes in the records. Arndal took exception to this in his report: "It is recommended that the therapeutic dietitian record her observations and recommendations in the medical record of patients on therapeutic diets."

Reviewing the minutes of departmental meetings during the workshop, the surveyors commented: "From the minutes recorded there appears to be an overemphasis on administrative discussions and only a single paragraph devoted to the scientific portion of the meeting, usually with no details of the cases presented and discussed." In the survey summation, Arndal and Fahlund added: "The minutes of clinical departmental

"WHERE'S THE EXPIRATION DATE?" *Dr. Fahlund asks E.R. supervisor Godfrey Duran (right) as he examines the sterilization stamp on a tracheotomy package on the E.R. crash cart. Duran explains that the hospital uses an automatic replacement system for its sterilized material, so there's no need for expiration dating by the hospital's Central Services Department.*

A PLEA FOR A FORMULARY *comes from pharmacist Wallace Slater (left), as hospital administrators listen. In asking surveyor Arndal (right) for J.C.A.H. help in establishing a drug list, Slater claims that doctors on Kettering's medical staff resist the idea on*





4. ...ne attending physician. ✓

5. The attending physician edits and authenticates the clinical entries of the house officers with notations as to agreement or disagreement. Yes ✓ No

6. Records are completed promptly after discharge (10-15 days). Yes ✓ No ✓ (see below)

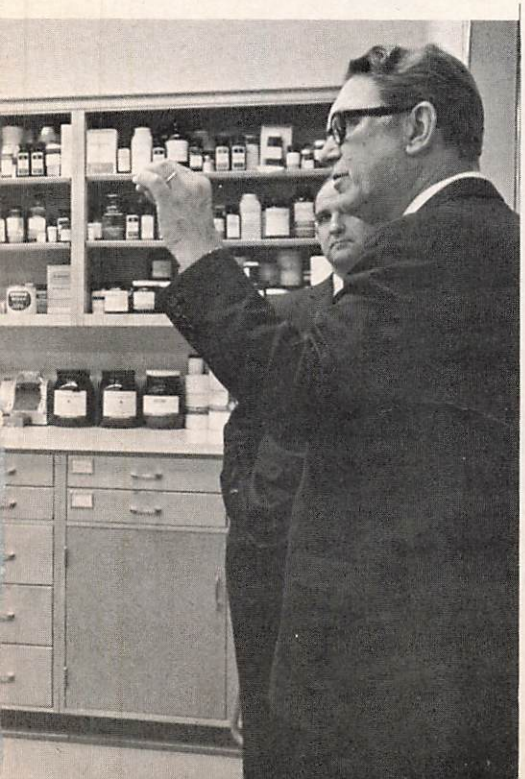
N. P. The overall picture of medical records is quite good, except for the subject of promptness and delinquency. The Medical Record Librarian and Records Committee have recently made a study of discharged records and found "numerous records of discharged patients without histories and physicals." There has been considerable resistance on the part of the medical staff to allow the Record Committee to review and evaluate current charts for promptness. This situation is about to be overcome as the staff has accepted the philosophy of review by the Admissions Committee and the Length of Stay Committee, which are a part of required Utilization function.

The review of different clinical records showed the filed record to be both complete and clinically pertinent except for a significant number of records with inadequate discharge summaries.

See Surgery and Obstetrics.

the grounds that it restricts their choice in drug selection. Arndal later noted in his survey: "A practicable, usable formulary or drug list should be published and kept up to date by the pharmacy committee . . . and be made available at all nursing stations."

TO KEEP RECORDS UP TO DATE, *Arndal advises chief of staff Ireton to have the medical records committee review the filed records as well as current ones to insure prompt entries. With Arndal and Ireton on their tour of the files are Dr. Fahlund (left) and records librarian Erma Simmons. Arndal made a point of referring to this matter in his report on medical records (above).*



COMMENTS AND RECOMMENDATIONS

#1 - The medical staff and administration should carefully review the current roster of staff appointments to verify the frequency with which the physician admits and cares for patients, and participates in and contributes to staff organization and responsibility, in order that the ~~physicians'~~ exercise of staff ~~of~~ privilege may be commensurate with ~~his~~ exercise of responsibility.

#2 - It is recommended that the department of general practice be an administrative and educational department. Since the department of general practice is not a clinical service and no patients are admitted to the department, the members of the department of general practice should on recommendation of the credentials committee, have privileges on the clinical services of other departments in accord with their training and experience. The general practitioners should attend the departmental meetings in their ongoing clinical review and evaluation of patient care.

#3 - The Accreditation Committee should be a multi-disciplinary activity with representation from all the hospital departments involved in the accreditation program.

#4 - The minutes of clinical departmental meetings should include adequate evidence of ~~the~~ review and evaluation of selected pertinent clinical cases. The minutes should include a brief clinical abstract, as well as the pertinent discussions.

#5 - The medical records committee should actively and thoroughly review the current, as well as filed records, to assure that the clinical entries are recorded promptly and in sufficient detail that the quality of medical care shown by the medical record is satisfactory, and report in writing to the executive committee of the staff.

#6 - The staff rules in regard to promptness and delinquency of medical records should be thoroughly enforced in order that current records may be completed within 24 hours of admission, and discharge records completed within 10 to 15 days after discharge.

#7 - All clinical records of patients hospitalized more than 24 hours, except normal obstetric and newborns, should have a complete discharge summary written and recorded, as suggested by the Joint Commission.

(CONTINUED)

Continuation Sheet Page no. 13

#8 - It is recommended that the therapeutic dietitian record her observations and recommendations in the medical record of patients on therapeutic diets.

#9 - A practicable, useable formulary or drug list should be published and kept up-to-date by the pharmacy committee of the staff and the administration of the hospital, and be made available at all nursing stations.

#10 - The prenatal record should contain more clinical information, especially in regard to prenatal visits.

#11 - Obstetrical patients delivered by caesarean section, as well as post-partum tubal ligations, should have a routine preoperative physical examination, as is done for all other major surgery.

#12 - Recorded evidence of preoperative study by dentists should include a dental history and physical examination, as well as a preoperative diagnosis.

WHAT THE SURVEYORS CONCLUDED *is set forth in their report under "Comments and Recommendations." When the Joint Commission "recommends" something, as in paragraphs 2 and 8 above, the hospital may follow the suggestion, as it sees fit. But when the report uses the word "should," the hospital* must *comply with the proposal or risk loss of accreditation.*

BURNING THE MIDNIGHT OIL *in their motel rooms, Drs. Arndal and Fahlund compare notes and dictate their report to Mrs. Arndal. It'll be forwarded to Joint Commission headquarters in Chicago for review and action. The two men's recommendation that Kettering be accredited for another three years was subsequently approved by the commission.*

meetings should include adequate evidence of review and evaluation of selected pertinent clinical cases. The minutes should include a brief clinical abstract as well as the pertinent discussions."

While Arndal went on with the workshop, Fahlund, accompanied by the chief of staff, made a grand tour of the hospital. They visited, in quick succession, the obstetrics department, operating rooms, recovery rooms, intensive-care unit, the emergency room, medical library, pharmacy, patients' rooms, and nursing stations along the way.

As the survey workshop drew to a close and the summing up conference ended, Kettering Medical Center president George B. Nelson stood up and addressed the participants in the accreditation survey. "Speaking as a former administrator, I must say this has been the most interesting survey I've ever witnessed. I'm impressed at the way it's been conducted and what we've learned."

Chief of staff Ireton agreed. "At the beginning, I thought this might be the same old Joint Commission nit-picking routine. It wasn't. I was certainly taken by surprise. I enjoyed being part of the survey, and I appreciate the questions you put to us and helped us answer."

Arndal and Fahlund, in turn, praised the hospital and its staff in their survey report: "There appears to be excellent liaison between the governing body, administration, and medical staff." They recommended Kettering Memorial Hospital be reaccredited for another three years. **END**

What's wrong with

By Robert L. Jewell

Each article in this series concentrates on a troubled practice and the hidden problem that wasn't at first apparent to the management consultant called in to survey the practice. The consultant's solution provides insights and tips to physicians who may—unwittingly—share the same problem.

In this article management consultant Robert L. Jewell takes a hard look at a practice that had everything going for it yet nosedived for no apparent reason. Getting it back in the air again took some careful sleuthing, a few phone calls—and a very long chance. Jewell is vice president of Medical Economics Consultants, Inc., in Dayton. He has disguised the names of the physicians and the aides in this otherwise factual account of a practice in trouble.

We all get annoyed, I suppose, when we find we've guessed wrong about something. That was how I felt one day about a year ago when two G.P.-brothers called me and said they needed some management help. I'd known them since the time I helped set up their billing system when they went into practice three years earlier. At that time, they'd declined our complete consultation service. By George, I'd bet myself, here at last are two doctors who won't make a wrong step on their own. After their phone call, however, I had to pay off my "other" self.

On the way to their office a couple of days later, I found myself weighing the drop in gross income the brothers had told me about against all the things they seemed to have going for them. Level-headed and intelligent, they had seemed headed for instant success. They'd established their practice in a well-tended professional building, beautifully situated on a tree-lined street in a prosperous and growing suburb. It offered ample parking and public transportation across the street.

That impression of a healthy practice continued after I parked my car and entered their offices. The furnishings still looked almost new, and the place was neat as a pin. The receptionist, a smart and attentive-looking girl in her late teens, quickly hung up her phone as I came in. It struck me that she looked strangely bothered by the call. "I'm Mr. Jewell," I told her. "I believe the doctors are expecting me."

"Oh, yes," she answered brightly if a little distractedly. "I'll tell them you're here." I glanced down and noticed that she'd had a file of patients' records before her during the phone call. Had the call interrupted her work on them or had the call caused her to get them from the files? Before I had a chance to wonder more, Bill Greerson, the younger of the two G.P.s, called me into his office where his brother, Terry, was waiting. We shook hands around and plunged immediately into a discussion of what had happened to their practice.

"We couldn't find the income figures you projected for us when we started out," Bill Greerson began. "But it seems to me that we're awfully far from them." He was referring to the income projections that my firm sets up as a part of our